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AFR/TR/HPN HIV/AIDS PREVENTION IN AFRICA
(HAPA) GRANTS PROGRAM

FINAL PROJECT EVALUATION
PVO HIV/AIDS PREVENTION IN AFRICA
MALAWI

FEBRUARY, 1990 THROUGH FEBRUARY, 1991

Submitted
by
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EXECUTIVE SUMMARY

Project HOPE's HIV/AIDS Prevention in Africa (HAPA) project in Malawi began in February, 1990 and ended in September 1991. This period covered the first phase of the project. It is therefore, necessary to evaluate the activities which have been implemented by the project, before Phase II starts.

The lessons learned from the evaluation will be used to develop the workplan for Phase II.

The Project contributed directly to the Malawi National AIDS control programme (MNACP) by training religious leaders in HIV/AIDS Prevention and Counselling. The trainers in turn, are supposed to train their peers to include HIV/AIDS prevention in their existing religious programmes.

The four-man evaluation team approached the evaluation of Project HOPE activities through Focus Group Discussions (FGD) and In-depth interviews (IDI) with individuals within the target populations of the three key intervention areas namely:

1. HIV/AIDS Education and Counselling Training of Trainers
2. HIV/AIDS education presentations and workshops
3. Technical assistance in educational program development and administration; information management.

The following were the key findings:

1. The trained trainers did not conduct follow-up workshops for their peers, but instead conducted briefings on HIV/AIDS education and prevention during their normal worshipping services. The multiplier effect did not happen as had been expected.
2. The information given during the briefings mentioned above appears to have been censored with respect to condom use. Information, Education and Communication (IEC) materials provided by the project were not passed on to their peers.
3. Vertical transmission of HIV (mother-to-child) appeared to have been not emphasized during briefings given by the trained trainers.
4. The distinction between giving advice and counselling was not clear. The church leaders were giving advice to clients instead of counselling because most of them still felt that they had a God giving-duty to lead and direct "lost sheep".
5. The leaders had difficulties accepting that extra marital relationships occurred amongst their peers who could therefore become HIV infected and develop AIDS. They had difficulties dealing with this type of individual.

6. The working relationship between PHAM and Project HOPE had not developed according to the Memorandum of Understanding (MOU) even after the Mid-term Progress Report of February 1991 had clearly highlighted this issue.

Based on these findings the following recommendations were made:

1. Project HOPE should develop a mechanism to ensure that trained leaders conduct workshops for their peers; that a monitoring system is in place to follow-up the activities of trained trainers as was pointed out in the Mid-term Progress Report of February 1991; and that a component of how to run such workshops should be emphasized during Training of Trainers.
2. Project HOPE should organize a workshop for church leaders to come-up with a unified approach to condom use and dissemination of IEC materials. Project HOPE should increase the use of audio-visual aids including passive approach to condom demonstration.
3. In view of the high sero-prevalence of HIV infection in reproductive age adults in Malawi, vertical transmission of HIV infection (mother-to-child) should be emphasized by Project HOPE.
4. Project HOPE should re-emphasize the aspect of establishing a helping relationship in counselling in their future counselling training workshops. These training workshops should also equip Church Leaders to provide counselling to their peers.
5. That Project HOPE/Malawi should come under the AIDS Secretariat and that it should work with PHAM like any other NGO. The Project HOPE HIV/AIDS Educator/Coordinator should become the NGO AIDS Coordinator at the Secretariat. The AIDS Secretariat should identify an NGO AIDS Coordinator's counterpart.

As a result of this evaluation exercise the evaluation team fully supports the continuation of Project HOPE HIV/AIDS related activities in Malawi.

I. INTRODUCTION:

Project HOPE's HIV/AIDS Prevention in Africa (HAPA) project in Malawi began in February, 1990 and ended in September 1991. The Project contributed directly to the Malawi National AIDS Control programme (MNACP) by training religious leaders in HIV/AIDS prevention and counselling. The trainers in turn, are supposed to train their peers to include HIV/AIDS prevention in their existing religious programmes.

The Project HIV/AIDS Educator (hereafter called Project Coordinator) is based at the AIDS Secretariat of the Ministry of Health from where he operates. The Coordinator's local counterpart is based at Private Hospital Association of Malawi (PHAM), the local counterpart of Project HOPE.

Project HOPE and PHAM agreed through a Memorandum of Understanding (MOU) to collaborate in carrying out certain aspects of the National AIDS Control Programme in preventing and controlling the spread of the AIDS epidemic in Malawi

The main purposes of the project were:

1. To provide PHAM with the technical assistance that would expand its institutional capacity to provide HIV/AIDS Information, Education and Communication (IEC) services beyond the duration of Project HOPE'S involvement. This was to be achieved in the area of IEC through provision of technical assistance to PHAM and the AIDS Secretariat to develop content, curricula, and material for HIV/AIDS prevention, patient care, management, and counselling. The training of personnel to conduct the programmes activities was also to be provided.

Technical assistance in the area of administration, management, supervision, and evaluation was to be provided in order to further institutionalize the capability for AIDS education and prevention within PHAM using the Primary Health Care (PHC) approach.

2. To focus on the training of leaders of the Protestant and Catholic organizations affiliated with PHAM and Muslim Association of Malawi, a non-PHAM related religious group.

National and Local Counterpart Organizations:

National Relationship: The Project HOPE has a five year country agreement with Malawi Government. The relationship with the National AIDS Control Programme is one of official

and coordinated and administrative support. In addition, the National AIDS Control Programme provides office space to the Project Coordinator and his secretary. The Project Coordinator is based at AIDS Secretariat and reports directly to the AIDS Control Programme Manager. The Project Coordinator also serves as the NGO Coordinator of the National AIDS Control Programme. The activities of the project were incorporated into the National AIDS Control Programme Reprogramming Document for Year II. The project's activities are seen as critical for disseminating information through the Christian Churches and the Muslim communities.

Local Counterpart:

The Private Hospital Association of Malawi (PHAM) was the local counterpart of Project HOPE to implement the project activities. The Project was responsible for the running costs of the project, including project staff salaries, expenses/costs incurred by PHAM related to the project implementation. The local staff were the PHAM AIDS Coordinator, Secretary/Computer Operators and a Driver. PHAM provided office space, and administrative and managerial support to the project staff based at PHAM.

II. EVALUATION METHODOLOGY

A. Purpose of the Evaluation:

The evaluation was aimed at finding out how far and well Project HOPE had met the stated objectives of the project. In doing this the evaluation team also hoped to identify those areas, where Project HOPE needs to work more, and those intervention areas that have not been carried out. These could become main areas of activities for Phase II. It is also hoped that the evaluation will identify areas of constraints and suggest possible solutions. To do this, the evaluation team developed a set of questions which were used for Focus Group Discussions (FGD) and In-depth interviews with individuals chosen from the target population. The questions were organized in such a way that they focused on three key interventions of the Project.

These key interventions are:

- a. HIV/AIDS education and counselling Training of Trainers workshops.
- b. HIV/AIDS education presentations workshop.
- c. Technical assistance in educational programme development, and administration; and Health information management.

The questions were made for the target population of PHAM affiliated church organizations and non PHAM affiliated organizations like the Muslims, and the Pan African Christian Women Alliance (PACWA), a Christian movement not affiliated to PHAM. Information from the key leaders was gathered through In-depth interviews using the same topic guide. However, questions for the In-depth interview with a PHAM official were different. They were specifically geared at the relationship between PHAM and Project HOPE. The questions were aimed at addressing the three categories of information, skills, and technical assistance. The questions were formulated to address the education and of the target population, finding out how much information they had gained through the training of Project HOPE staff, and how much of that information they understood or did not understand. The questions were also intended to find out how much information on HIV/AIDS they knew before they had the workshops.

On the skills, the questions were aimed at finding out how/what skills were acquired and how well they used them, and in what areas they still needed help.

The next set of questions explored the technical assistance; where the intention was to find out what help they had received in terms of IEC materials. There were also questions of attitudes, feelings and peoples' reactions to certain aspects of the programme. The questions used are in appendix II A. & B.

B. The Composition of the Evaluation Team

The details of the four man evaluation team are in appendix.

C. Methods Used

Major Information sources: The Evaluation Team identified key groups and individuals in the project's activity areas in the three regions of the country. The groups and individuals chosen were those who had interacted with Project HOPE staff during training and those that were in a position to go and train others. With the exception of the Muslims, all these individuals and groups interviewed are churches that belong to Christian Council of Malawi (CCM), Episcopal Conference of Malawi (ECM) and affiliates of PHAM. The Muslim groups and individuals belong to the Muslim Association of Malawi.

Means of Gathering Information: The Evaluation Team used two methods of gathering information; Focus Group Discussion and in depth interviews with the groups and individuals respectively. The focus groups consisted of 8 - 10 individuals all of whom were either priests, church leaders, youth, women's groups reverends individuals for in-depth

interviews were chosen from a short list provided by Project HOPE staff. Members of the focus groups were identified by their coordinators.

The Evaluation Team had also as a reference the Mid Term report submitted in February 1991. The report highlighted the successes of Project HOPE so far, and pointed out some of the problem areas.

After completing the Team met at the end of each interviewing session to discuss their findings in order to reach common consensus which formed the basis of the recommendations. The Evaluation Team has submitted this report to Project HOPE in country office. It is hoped that Project HOPE will share this information with National AIDS Control Programme the funding agency and other interested bodies.

D. Evaluation Schedule and a list of Informants
(See appendix III)

III. FINDINGS OF THE EVALUATION

A. Design:

The Project design took into consideration the findings and recommendations of the Medical Association of Malawi meeting of March 1990; the March 1990 annual review of National AIDS Control Programme and the KABP survey undertaken by the NACP. The Report to the AIDS control Programme Review Team of the United States Agency for International Development Support for AIDS control was also available and used.

These reports strongly recommended the mobilization of religious communities to assist over burdened health care personnel to provide HIV/AIDS education and counselling services.

The KABP findings were used to assist to develop Information, Education and Communication (IEC) materials and training materials for the project target groups and the general public including messages to dispel rumors and misconceptions about HIV and AIDS.

The Project through Christian Council of Malawi (CCM), Episcopal Conference of Malawi (ECM), Muslim Association of Malawi (MAM) was to train the following target number of persons:

1.	Religious Leaders		
	Catholic/Episcopal Priests and Sisters	=	221
	Catholic Deans	=	14
	Protestant Ministers	=	120
	Muslim Leaders	=	227
2.	Church affiliated Youth Leaders		
	Catholic/Episcopal Youth Chaplains	=	7
	Protestants	=	17
	Muslims	=	16
3.	Church affiliated Women's group leaders		
	Catholic women	=	64
	Protestant women	=	61

By the end of the project the major changes were the number of persons trained directly by the projects as indicated below.

Protestant Ministers	600
Catholic Priests, Nuns and Village Church Instructors,	400
Youth Leader/Coordinators,	81
Muslim Leaders (both men and women)	432
Women Group leaders	100

These figures far exceed what the project had planned, and reflect prudence and training cost cautiousness by management. Project staff have given HIV/AIDS Prevention and Control talks/presentations to over 25,000 church and community members.

The main strategy of the project was using training of trainers workshops. Each TOT workshop took three days. The training focused on how to deliver HIV/AIDS education presentations and conduct training, and also provide preventive and psychosocial support counselling.

The training methods used were both didactic (lectures and demonstrations) and active participation processes, including questions and answers, role plays, dramas, group work, use of audio visual materials, songs and practice sessions. The content of the sessions were:

- (a) Facts about AIDS, including modes of transmission and prevention
- (b) Communication skills
- (c) Counselling skills
- (d) High risk behaviors
- (e) Consequences of AIDS
- (d) HIV/AIDS Education (How to give)
- (e) The Role of the Church in HIV/AIDS Education/Prevention
- (f) HIV/AIDS Education Plan of Action for your parish or congregation.

The primary trainers for this were the Project HOPE Coordinator and PHAM AIDS Coordinator. Other expert assistance was provided by AIDS Secretariat and Health Education Unit of Ministry of Health and WHO/GPA Team.

The training goals were to train these leaders to deliver one to one or group presentation/counselling that was intended to modify the knowledge, attitude or behaviour of person (s) receiving the intervention. The training were conducted at regional, district, diocesional and congregational levels.

After training, monitoring and supervisory visits were conducted at selected areas to monitor activities by the trainers.

The impact area was nation wide, but specifically with emphasis on PHAM catchment areas. Choosing to work with Church leaders was in response to the recommendations mentioned on page

The Project was staffed by:

- (1) Projector Coordinator, expatriate based at AIDS Secretariat
- (2) PHAM AIDS Control Coordinator based at PHAM.
- (3) 2 Secretary/Computer Operators (one at AIDS Secretariat for the Project Coordinator and the other at PHAM for PHAM AIDS Coordinator).
- (4) A driver at PHAM
- (5) Office Clerk at AIDS Secretariat.

Through the Christian Council of Malawi, Episcopal Conference of Malawi, Muslim Association of Malawi the TOT workshop volunteers were identified at Regional and district levels.

These volunteers performed the functions of (a) identifying key religious leaders for training (b) monitoring and supervising activities in their areas and reporting to the project office in Lilongwe. (c) Serving as a link between the project staff and the community/church (target group).

How the project was staffed:

The project was staffed by :

- (a) One expatriate Project Coordinator, who was responsible for project administration, financial management, technical content and health information system.
- (b) PHAM AIDS Control Coordinator, Malawian, counterpart to the Project Coordinator.
- (c) Two Secretary/Computer Operators - (one assigned to the Project Coordinator and the other to PHAM AIDS Control Coordinator).
- (d) One project driver based at PHAM.

Technical backstopping and coordination, and administrative assistance/support were provided by Dr. Marjorie Souder, Project HOPE HIV/AIDS Coordinator, Dr. Carolyn Kruger, Country Manager for Malawi, both at Project HOPE Headquarters and Dr. Tom Kenyon, Project HOPE's country Director based in Swaziland.

The National AIDS Secretariat, Health Education Unit of the Ministry of Health, WHO/GPA Country Team and PHAM provided support and assistance during workshops.

How volunteers were utilized and supervised:

Volunteers at the regional, district, parish and community levels were used to organize and conduct presentations at their various levels. They also served as a link between the project and the target population. Three main persons were identified in each of the regions and these persons supervised activities in the regions.

Supervision was also provided by the Youth Coordinator of the Christian Council of Malawi (CCM), and other key persons from Episcopal Conference of Malawi (ECM) and Muslim Association of Malawi (MAM).

The supervisors also completed a supervisory checklist form for monitoring activities and sent them to Project HOPE.

How it was integrated with other local institutions:

The National AIDS Control Programme considered the project as part of the overall Government of Malawi effort to fight the epidemic. The project was physically based at the offices of the AIDS Secretariat/ Ministry of Health, therefore, collaborated on all activities with AIDS Secretariat. The Project Coordinator counterpart based at PHAM helped PHAM to include HIV/AIDS education and counselling into most of PHAMs Primary Health Care activities.

How the community was involved

The religious leaders trained were selected from the community where they worked. Community participation was seen as a viable component of the project activities.

The strengths and constraints of the design of the project:

In the original design of the project the Project Coordinator was supposed to be based at PHAM. However that was changed and the Project Coordinator was based at the AIDS Secretariat. This new arrangement helped the project to get tremendous support from the Government of Malawi.

The project, with support from the Government managed to get the religious leaders and communities involved in HIV/AIDS Control activities.

Because of this project, USAID has been able to identify areas where to work with other NGOs, i.e. Private/Commercial Sectors.

Constraints:

- (1) Interaction between project counterparts was difficult due to the fact that they were located at separate offices.
- (2) PHAM's receipt of funding from Danchurchaid created extra burden of activities on the PHAM AIDS Coordinator. This also led to division of activities between the Project Coordinator and PHAM AIDS Coordinator, the counterpart.
- (3) PHAM's weakness to provide administrative and management-support and lack of direction by PHAM's administration for its AIDS control project made timely implementation of programmed activities difficult.

B. PROCESS

In order to monitor the effectiveness and quality of its major activities Project HOPE developed and utilized several instruments and these are:

- a). Training Workshop Report form: indicates the kind of group (priests or nuns or both) the number of participants as well as the pre and post test results
- b) Group Health/AIDS Education Return form. this form indicates the method of training used, the audio-visuals used (if any) and the number of days, the training took.
- c) Supervisory Checklist form is supposed to be filled by one of the trained people who had carried out an activity with his peers following the training of trainers workshop. It monitors specifically the activities carried out, problems encountered, and how they were solved, what future help and action was needed.
- d) HIV/AIDS Education Presentation/Workshop Reporting form.

This form is designed to give information on the presentation of HIV/AIDS education by those people trained by Project HOPE. It asks for the format of presentation, the length and the type of audience.

- e) Project HOPE/PHAM AIDS project Training Workshop Tally Sheet: This form compares the individual scores of the participants in a pre and post test, to find out if learning has actually taken place.

The trained leaders who are supposed to train their peers also write a report on the workshop they had conducted.

All these instruments gave Project HOPE an idea of what progress was being made. The evaluation team looked at these forms, and read the reports and concluded that overall the various activities were carried out well.

These records show that some of the trained leaders carried out the training of their peers, although the reports indicate that this was more of information giving than actually training. Project staff trained the leaders in all aspects related to HIV/AIDS and the trained leaders in turn chose one aspect from the subject, e.g. prevention, and dwelt on it. This may reflect difficulties in completing the reporting forms which are in English. What the forms show is that some follow-up activities were done.

As for the Project staff presentations, the workshop reports written by those individuals who participated were more than complimentary. The written reports point out to the quality and relevance of training on the subject. This came out in the Focus Group Discussions and In-depth interviews. Those who attended felt that it were better if the Project staff reached more of their peers instead of them going and repeating what they had learned. The pre and post test results show that there was a significant improvement in the knowledge acquired through the training sessions.

C. OUTPUTS

Judging by the responses in the interviews and the written reports, Project HOPE has accomplished the planned activities in the DIP. Since its inception the Project has achieved the following in line with its objectives set out at the beginning:

1. developed the content for the training of trainers
2. developed an inventory of education materials in AIDS Secretariat and PHAM (See appendix V)
3. developed an inventory curricula for specific target groups e.g. the Muslims
4. developed guidelines for counselling in PHAM Units; Training Manual in Counselling, Counselling Guidelines, and Counselling Policies.
5. distributed more than 20,000 AIDS booklet "KODI EDZI N'CHINYANI/WHAT IS AIDS"

Project HOPE had projected to distribute about 10,000 booklets by the beginning of this year, however this number was exceeded by far because of the collaboration with the AIDS Secretariat.

In addition to developing materials Project HOPE conducted training of core teams of specific target groups with the idea that these groups would in turn train their peers, producing the multiplier effect.

D. OUTCOMES

It was clear to the evaluation team that Project HOPE's output according to objectives 3, to 7 was impressive judging by the way people responded in the interviews. From the evaluation, the team noted that the education of the target population on what AIDS is and its modes of transmission and prevention was well done. For example one respondent said " I now have a better understanding of this disease than I had before.

1. As far as their change of behaviour was concerned one youth reported that he had seen some notable positive changes in behaviour particularly among the girls in his village.
2. The evaluation team also found out that attitudes towards those with HIV/AIDS had changed from being judgmental to empathetic, e.g. one respondent said "I have no reason to condemn them, tomorrow it may be me."
3. However, as reported elsewhere, the issue of vertical transmission (mother to child) of HIV and the natural history of infection from exposure of HIV to the development of the clinical AIDS appears not to have been well understood by some of the respondents, e.g. they always assumed that in a couple, the individual who develops the clinical disease AIDS first is responsible for bringing the infection in the family.

On the prevention side, almost all of them agreed that abstinence and sticking to one partner was the best. However, when it came to the use of condoms as a preventive measure against getting or transmitting HIV there was a problem. Most of them felt that to promote the use of condoms was "encouraging and advocating promiscuity". This feeling was strongest among the church leaders both men and women. They were not sure what they would say about the use of condoms without projecting an unfavorable image of themselves, amongst their peers and congregation. It was reported that some of the trained church leaders objected to condom adverts on the radio and public condom demonstration.

In spite of their uneasiness on the use of condoms for the unmarried people, most of the trained clergy, men and women

expressed the need to want to get involved in counselling people with AIDS. Most of the clergy saw counselling as an opportunity to proselytise those people who would have otherwise died as heathens. Some moaned the fact that the community was not quick in recognizing their skills as counsellors and were asking the AIDS Secretariat to assist. One respondent pointed out that she had written to the Ministry of Health that she was available as a counsellor but did not receive a response at the time of the interview. The evaluation team found out that materials received were not enough for everyone, or sometimes the materials were kept in someone's office. However, the respondents reported that heshowing of video AIDS tapes had been very helpful and had left an outstanding impression. They requested for more videos to be made available preferably with a Malawian setting, and in the local language.

On differentiating between project HOPE and PHAM, most of the people interviewed could not differentiate the difference, they saw Project HOPE and PHAM as one.

Shortfalls The evaluation team had the general impression that the people had all the information they needed and that it was made clear to them to go and train their peers who would in turn teach others. However, the multiplier effect did not take place because the trained leaders did not train others. They felt that compared to Project HOPE staff standards of training they could not do a better job, and therefore wished, (and this came out in all of the interviews) that the project staff should do all the training all the way down. Most of them did not attempt to focus on what they could do well, they instead focussed on how well the Project staff had taught them, and how others would have benefitted if they had also been taught by the Project staff. Evaluation Team thinks that emphasis should be made on the importance of the trained leaders to train others. Project staff cannot train all the church leaders.

E. SUSTAINABILITY OF THE PROJECT

The original plan to sustain the project after HAPA funding was completed was for the churches to continue the activities with the support of the local counterpart organization. PHAM, and the Ministry of Health. PHAM support will be particularly funded by Danchurchaid. However, this will not include activities carried out by the Muslim organization. The Ministry of Health support will be the Ministry of Health/AIDS Control Programme. This could include support of activities carried out by the Muslim community.

The local USAID Mission has been very pleased with the project achievements in Phase I. and have agreed to extend the project funding for an additional two years (Phase II).

The PHAM AIDS Coordinator has received sufficient training (both in country and external) to enable her to carry out project activities without being supervised by the Project Coordinator.

During the interviews, respondents emphasized the need for Project HOPE to continue providing materials and technical assistance. The Evaluation Team noted that the various religious organizations had not themselves discussed the issue of how to sustain the activities after Project HOPE's funding is completed.

F. Staffing and Technical Assistance

The staffing plan as described in part A, was not completely adequate. There was the need for an Administrative Assistant to help with administration and finances. This was identified in the middle of the project.

Technical backstopping, coordination, and administration was provided by project HOPE Headquarters and Regional Office in Swaziland.

Specifically, technical backstopping and coordination was provided by Dr. Marjorie Souder, Project HOPE HIV/AIDS Coordinator; Dr. Carolyn Kruger, Project HOPE Country Manager, for Malawi; and Dr. Tom Kenyon, Project HOPE Country Director, based in Swaziland provided administrative support. The technical assistance was provided both from Project HOPE Headquarters and also during field visits by the persons mentioned above.

Mr. Clifford Olson - Project HOPE Health Information Systems Consultant, visited the project to design the HIS for monitoring and reporting of project activities from the field.

Training for project staff

(1) PHAM AIDS Project Coordinator was sent to The AIDS Support Organization (TASO) in Uganda in March and to Chikankhata, Zambia in July for field visits sponsored by the Project. PHAM AIDS Coordinator has also visited Kenya, Uganda and Zimbabwe under different sponsorships. Additionally, she has participated in-country workshops and seminars to equip her with the skills to run the PHAM AIDS project.

(2) The two Secretary/Computer Operators have been trained in the use of Lotus 1-2-3, and dbase up to advance levels. Staff received informative magazines, journals and periodicals regularly from Project HOPE Headquarters and other international organizations such as WHO/GPA. Mr. Clifford Olson provided technical assistance in HIS and Dr. Marjorie Souder provided assistance in programme planning which were very useful in the implementation of project activities.

There is still need for more training in the use of computers and project management for the Administrative Assistant.

As much as possible the project utilized local consultants wherever necessary.

IV. LESSONS LEARNED AND RECOMMENDATIONS

A. LESSONS LEARNED

The following are the lessons learned from the evaluation:

1. The target population had been reached and made aware of the disease AIDS, and its social ramifications and the religious leaders role in prevention and control. All they needed was more reinforcement and encouragement to teach others.
2. Where attempts to teach others had been made, there had been deliberate censorship of some of the information received during Training of Trainers, e.g. information on condoms had been deliberately omitted during briefings. Similarly little mention was made of vertical transmission of HIV as a significant mode of HIV spread.
3. In the TOT workshops participants were taught and practiced the counselling skills. However, few of them actually practiced the skills or taught others how to counsel. There was also confusion between giving of advice and counselling. This may reflect their lack of confidence.
4. It was found out that many women despite receiving training on HIV/AIDS prevention and control, were uncomfortable to talk to their husbands regarding what to do about AIDS prevention; e.g. condoms, faithfulness in the family and talking to children.
5. Issues of project activity sustainability appear not to have been discussed among the religious leaders although the issue of the need to continue project activities was clearly expressed.
6. Use of cinematographic materials e.g. AIDS video tapes appears to have had longer lasting impression on the target population. Other IEC materials did not reach the intended beneficiaries because of insufficient numbers distributed and some were held by some of the trained religious leaders.
7. The current monitoring system using reporting forms in English does not appear to give the required information for the project staff. Many of the Project target population working language is Chichewa.

8. Certain positive behaviour changes as far as HIV transmission is concerned have been reported amongst the target community. These include circumcision being done with individual razor blades or being referred to the hospital, and an increase in the use of condoms and free discussions of AIDS situation in Malawi.
9. The relationship between Project HOPE and PHAM still remains unsatisfactory; there appears to be no full commitment by PHAM to the Memorandum of Understanding (MOU) between Project HOPE and PHAM even after the recommendations made in the Mid-term Progress Report of February, 1991.

B. RECOMMENDATIONS

Based on the lessons made, the evaluation team makes the following recommendations:

1. Project HOPE should develop a mechanism to ensure that trained leaders conduct workshops for their peers; that a monitoring system is in place to follow-up the activities of trained trainers as was pointed out in the Mid-term Progress report of February 1991 and that a component on how to run such workshops should be emphasized during Training of Trainers.
2. Project HOPE should organize a workshop for church leaders to come up with a unified approach to condom use and dissemination of IEC materials. Project HOPE should increase the use of audio-visual aides including passive approaches to condom demonstration.
3. In view of the high sero-prevalence of HIV infection in reproductive age adults in Malawi, vertical transmission of HIV infection (mother-to-child) should be emphasized by Project HOPE.
4. Project HOPE should re-emphasize the aspect of establishing a helping relationship in counselling in their future counselling training workshops. These training workshops should also equip church leaders to provide counselling to their peers.
5. That Project/HOPE Malawi should come under the AIDS Secretariat and that it should work with PHAM like any other NGO. The Project HOPE AIDS Coordinator should become the NGO AIDS Coordinator at the Secretariat. The AIDS Secretariat should identify an NGO AIDS Coordinator's counterpart.
6. During training project HOPE should encourage participants to explore ways of discussing AIDS prevention between couples amongst families including discussing with the children.

7. The church leaders be encouraged to explore means of continuing the Project activities amongst themselves after the project funding has stopped.
8. In view of these lessons and recommendations, the project should review the training curriculum and modify it taking into account the experiences learnt from PHASE I.

As a result of this evaluation exercise, the evaluation team fully supports the continuation of Project HOPE HIV/AIDS related activities in Malawi.

APPENDIX 1
COMPOSITION OF THE EVALUATION TEAM

V. APPENDICES

1. Composition of the Evaluation Team

Mr. Samu M. Samu, Team Leader :	Lecturer in Language and Communication. Bunda College, University of Malawi.
Mr. P. Kantunda Team member :	Primary Health Care Coordinator, PHAM.
Dr. G. Liomba Team member :	A I D S C o n t r o l Programme Manager.
Mr. R. Ngaiyaye Team member :	Health Education Officer in charge of Health Education Unit.

APPENDIX 2
TOPIC GUIDE FOR FGD AND IDI

2. Topic guide for focus group discussion and in-depth interviews

A. EDUCATION AND INFORMATION

1. Do you know anything about AIDS/HIV?
2. How did you know about AIDS/HIV?
3. What were your initial reaction when you heard about HIV/AIDS
4. Have you attended any meetings about AIDS/HIV?
5. Who organized these meetings?
6. What did they talk about?
7. Did you learn anything new about HIV/AIDS that you did not know before?
8. Was there any part of the message that you disagreed with or did not understand.
9. Were these meetings enough/or too much?
10. Did you receive any materials? what were they?
11. Have you watched any videos? What do you think about them?

B. COUNSELLING SKILLS

12. If you were going to say something to those with HIV/AIDS. What would you say?
13. If you were going to say something to those without HIV/AIDS What would you say?
14. What areas would you emphasize?
15. If you were HIV positive or had AIDS what would you need most?

C. IMPARTING SKILLS: TRAINING OTHERS

16. What have you been able to do since attending those meetings?
17. What else do you think should be done about HIV/AIDS?
18. If you were to advise the Government about HIV/AIDS what would you say?
19. Why do you think there is a high degree of immorality despite the teachings of the church for the last 50 years?

APPENDIX 3
TOPIC GUIDE FOR IDI WITH PHAM

3. Topic guide for an in depth interview with the PHAM Deputy Executive Secretary

1. What can you say about the PHAM AIDS Control project even since Project HOPE came in?
2. What can you say about the relationship between PHAM and Project HOPE?
3. Are you happy or satisfied with the present relationship?
4. Is the Memorandum of Understanding being adhered to?
5. What aspects of the MOU are you not happy with?
6. What other support has PHAM received from Project HOPE?
7. What is the future of Moslem training by PHAM after Project HOPE phases out?
8. What resources has Project HOPE provided for the programme that have assisted and are assisting PHAM. What materials have they provided PHAM?
9. Is there anything you would have wanted to see Project HOPE do, that is not being done now?
10. Can you comment on the PHAM AIDS Coordinator workload?
11. If Project HOPE were to continue what would you like to see them doing?

APPENDIX 4
EVALUATION SCHEDULE

4. Evaluation Schedule

<u>DATE</u>	<u>PLACE</u>	<u>PERSONS(S) GROUP</u>	<u>TYPE OF INTERVIEW</u>
<u>SOUTHERN REGION</u>			
1. 11/10/91	Blantyre	Mrs G. Kapuma & Rev. S.A.S. Njala of CCAP. Muslim women Blantyre Islamic Centre.	IDI
2. 12/10/91	Limbe	Father Kasiwaya Vicar General of the Anglican Diocese S. Highlands. Limbe.	IDI
<u>CENTRAL REGION</u>			
3. 15/10/91	Lilongwe	Mr. M. Zulu, Deputy Executive Secretary of PHAM.	IDI
4. 15/10/91	Lilongwe	Mr. E.M. Choonara Chairman of the Lilongwe Islamic Movement.	IDI
5. 15/10/91	Lilongwe	Rev. Kadawati Youth Coordinator, Christian Council of Malawi.	IDI
6. 16/10/91	Lilongwe	Father William - Nankhanga Parish.	IDI
7. 16/10/91	Nkhotakota	Mrs E.J. Chombo - PACWA National Coordinator.	IDI
8. 17/10/91	Salima	Muslim Youth, Salima Islamic Centre.	FGD
<u>NORTHERN REGION</u>			
9. 18/10/91	Ekwendeni	Rev. Mhone Medical Coordinator Livingstonia Synod. Group of Reverends Group of Elders, Community members	IDI FGD FGD

APPENDIX 5
LIST OF INFORMANTS

5. List of Informants
MUSLIM WOMEN - BLANTYRE ISLAMIC CENTRE

Mrs Fatima Ndaila
Mrs A. Tepani
Mrs R.O. Maunde
Mrs C. Rajabu
Mrs H.H. Matola
Mrs Khan

SALIMA ISLAMIC CENTRE, SALIMA

Ismail Ajawa
Suleiman Khalid
Abdulbadir Rajas
Salim Mohammed
Abbasi Ali
Rashid Ayami
Salid John
Khalid Luzinga
Daudi Ali
Yahaya Mazanda
Ali Kennedy

ANGLICAN YOUTH LILONGWE

Frazer Wandika
Haziwell Banda
Meria Namalaka
Kotifida Tsaka
Sten Kambewa
Prisca Mtenje
Mai Mwalabu

CHURCH ELDERS - EKWENDENI

Mr. F. Ngwira - Chilumba
Mr. M. Hara - Embangweni
Mr. M. Gondwe - Karonga
Mr. J. Nyirenda - Jenda
Mr. H. Chavura - Ekwendeni
Mr. O. Mkandawire - Nkhamanga

GROUP OF REVERENDS - EKWENDENI

Rev. P. J. Msimuko
Rev. M.C.E. Munthali
Rev. H.G. Gondwe
Rev. W.G.M. Msowaoya
Rev. L.A. Tembo
Rev. N.G. Hara
Rev. A.M. Mfuné
Rev. J.A. Sikwese
Rev. A.P. Longwe

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APPENDIX 6

LIST OF BOOKS USED FOR CHURCH LEADERS' WORKSHOP

6. List of Books used for church leaders workshops

What is AIDS? A manual for Health workers - by Christian Medical Commission.

- AIDS Education Guide for Non-Health Workers - MACP
- Materials produced by Lingadzi CCAP: Health Committee on Guidelines for Caregivers of People with AIDS and their families.
- Counselling Manual - MACP (Draft)
- Church and health in the World - To Live: Why AIDS
- Preventing a Crisis - AIDS and Family Planning
- The Churches Response to the Challenge of HIV/AIDS
- The Handbook for AIDS Prevention in Africa
- Living Positively with AIDS - TASO - Uganda
- From Fear to Hope - Chikankhata Hospital, Zambia
- AIDS Management
- WHO AIDS Series
- Family Health International
- Calming the Storm - Christian Reflection on AIDS
- AIDS Action - Issues from AHRTAG
- Materials from Muslim Community
- AIDS Posters/Booklets

OCCGE

EPIGEPS() PROPOSAL*

STRENGTHENING THE CAPACITIES OF OCCGE MEMBER STATES IN FIELD EPIDEMIOLOGY AND MANAGEMENT OF PUBLIC HEALTH PROGRAMS

Presentation Note

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- 1 - CONTEXT, HEALTH PRIORITIES AND CHALLENGES IN AFRICA
- 2 - PROJECT GOALS AND OBJECTIVES
- 3 - STRATEGIES AND APPROACHES FOR ACCOMPLISHMENT
- 4 - PROJECT COST ESTIMATES
- 5 - POTENTIAL BENEFITS OF THE PROJECT
- 6 - AID REQUIRED FOR THE PROJECT
- 7 - DECISIONS TO BE MADE

(*) EPIGEPS French abbreviation for
Epidémiologie et Gestion des Programmes de Santé Publique

OCCGE - APMP - CDC - IDEA
November 12, 1991

DB

1 - CONTEXT, HEALTH PRIORITIES AND CHALLENGES IN AFRICA

The International Community is in accord that the progress made during the 1980s is being placed in jeopardy by the severe economic and social crisis presently spreading across Africa. In a health content, this crisis is characterized by high rates of infant mortality, a small percentage of the population having access to safe drinking water and to health services, a high fertility index, a high growth of urban population, a recurrence of epidemics (cholera), an increase of malaria and of the new threat of AIDS.

The health development of the continent is in a state of limited advancement due to:

- poor management and therefore poor performance of health structures and institutions;
- inadequacy in the training and utilization of human resources for health;
- the shortage or absence of health information available for decision making;
- the lack of material, technical and financial resources.

In addition, following the *Children World Summit* (New York, September 1990), then the *WHO World Assembly* (Geneva, May 1991), and the *WHO/AFRO Regional Meetings* (Bujumbura, September 1991), the accent was placed on the need for an exceptional mobilization of the resources and energy of the International Community in order to support health promotion for the development of African countries.

The implementation of this effort rests upon:

- the availability and quality of a critical mass of African human resources, available at various levels of the African health establishment (regional, inter-State, national, intermediate and local);
- the intensification of cooperation between African nations;
- collaboration within the United Nations system;
- international cooperation.

The sub-regional African organizations (OCCGE, OCEAC, CEPGL, COI, UMA, UDEAC, CDEAO...) constitute, for OCCGE member states, a pool of organizations capable of an array of great contributions in response to the challenges of the African health problem. In this respect, the OCCGE which has the benefit of some thirty years of scientific and technical health cooperation among eight African Francophone states, à priori represents a pool within which this new institutional dynamic may be carried out.

2 - PROJECT GOALS AND OBJECTIVES

GOAL OF THE PROJECT:

To improve health services performances in West Africa by strengthening the technical capacities of the Ministries of Health and the professional competence of the staffs, to develop effective health policies and manage public health programs.

OBJECTIVES:

o *At the inter-State level:*

To develop at the Secretariat General of the OCCGE, expertise and a professional training program in field epidemiology and health project management capable of:

- promoting and coordinating the collection, analysis, publication and dissemination of health information;
- intervening in the event of epidemic phenomena;
- carrying out evaluations of health actions and;
- providing management tools appropriate for the management of public health programs of the member States.

o *At the national level and decentralized level:*

To strengthen and standardize the public health surveillance systems of the OCCGE member states and particularly to improve the capacity of technical services of the Health Ministries to collect, compile, analyze, publish and disseminate data from surveillance of diseases and injury.

DURATION OF THE PROJECT:

The minimum duration planned for the project is six years, at the end of which an extension of three years may be considered based on the results obtained from the evaluation.

3 - STRATEGIES AND APPROACHES FOR ACCOMPLISHMENT

The project is based within the General Secretariat of the OCCGE in Bobo-Dioulasso, Burkina Faso, under the authority of the Secretary General.

The Ad hoc inter-agency committee will be formed to mobilize financial resources, technical validation and project follow-up. Its permanent secretariat will be provided by the general Secretariat of the OCCGE.

Management of the project is provided by the Project Director and appropriate support staff. Eight country instructors are responsible for the day-to-day supervision of the residents in the 8 OCCGE member nations.

Two residents from each country are accepted each year in each of the two tracks. Initially, the program will involve three countries. Then every year three other countries will be included in the project. By year 3, all OCCGE member States will be part of the program.

This is a two year training program in both field epidemiology and public health management. It begins with an introductory 8 week session which includes a joint track for both Epidemiology and Management residents then residents from both tracks spend the remainder of the introductory session covering topics in their respective fields of interest.

In the remaining 22 months, the trainees put into practice the field epidemiology and health program management methods attained, under the supervision of instructors and consultants. The nature of specific assignments will vary.

During the program, the residents participate in continuing training sessions (two in the first year, four in the second) organized in Bobo-Dioulasso or in the member nations. These meetings are the occasion for the residents to participate in conferences and in exercises on the detailed methods of biostatistics, epidemiology, surveillance and management, and present work carried out in the field. These one week meetings promote a group dynamic and stimulate the exchange of experiences among the residents.

The residents are also encouraged to organize seminars and participate in national and international meetings. They may also be consulted on ad hoc problems originating in the OCCGE member countries.

4 - PROJECT COST ESTIMATES

SUMMARY OF VARIOUS POSITIONS	YEAR 1	YEAR 2	YEAR 3	TOTAL
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IN THOUSANDS OF FCFA				
CAPITAL IMPROVEMENT	301 350	101 850	105 000	508 200
OPERATIONS	245 722	69 138	689 288	1 404 148
PERSONNEL	333 055	486 900	586 350	1 406 305
HEADQUARTERS EXPENSE (15%)	139 385	154 185	199 385	492 954
TOTAL	1 068 615	1 182 085	1 528 615	3 779 314

IN THOUSANDS OF DOLLARS (1\$ = 0 FCFA)				
CAPITAL IMPROVEMENT	1 005	340	350	1 694
OPERATIONS	819	1 564	2 298	4 680
PERSONNEL	1 110	1 623	1 955	4 688
HEADQUARTERS EXPENSE (15%)	465	514	665	1 643
TOTAL	2 588	6 601	4 745	10 904

The cumulative budgeted expenses of the first three years of the project amount to 3.8 billion FCFA or 11 million dollars.

The progression of expenses has been calculated in accordance with the increase of project activities and the recruitment of additional permanent personnel and residents.

The elements of capital improvement, operating expenses, and personnel costs represent 15%, 42% and 42% of the total expenses budgeted for the first three years of activity,

respectively. Supplies and data processing equipment (36%) and transportation costs (25%) comprise 61% of the cumulative total investment.

Priority will be given to capital improvement related to the rebuilding of the infrastructure which will support the Project at the OCCGE Headquarters (15% of the total budget).

More than 25% of the operating expenses - outside of personnel charges - will be devoted to travel and per diem of residents and training staff, 15% to cover the costs of communication and telecommunication, and more than 25% for road and air transport. Most of the operating expenses will be devoted to the support of mobility.

5 - POTENTIAL BENEFITS OF THE PROJECT

- ◆ Establish a permanent and common network within OCCGE member States of experts capable of making appropriate and timely decisions related to epidemiology and the management of health programs.
- ◆ Facilitate the exchange of reliable epidemiological information among Health Ministries of the OCCGE member states, which acquire the ability for resolution and immediate action.
- ◆ Stimulate technical perfection, communication and the exchange of interdisciplinary experience among African public health staff.
- ◆ Establish a network of competent health managers, using techniques of health program management appropriate to specific environments at all levels of the health systems of OCCGE countries.
- ◆ Contribute to the institutionalization of existing programs and facilitate the inclusion of new programs within the framework of a regional operational structure.
- ◆ Contribute to the effectiveness of performance and the efficiency of priority health programs, such as the eradication of Guinea worm and poliomyelitis and the elimination of neonatal tetanus in western Africa.

6 - AID REQUIRED FOR THE PROJECT

The Health Ministries of the member States should provide logistical support to the Project teams operating in their territory and under their responsibility. International partners should provide the technical specialized assistance. A significant financial participation must be mobilized by the international financial partners involved in this Project. The initial high cost of the programs will be quickly reduced as soon as a critical mass of African experts is created.

7 - DECISIONS TO BE TAKEN

The Administrative Council will decide to :

- adopt EPIGEPS pre-project;
- create an Ad hoc Inter Agency committee that will monitor the fund-raising, the development the training program and recruitment of staff and residents;
- will mandate all the Ad hoc committee members to participate in preparatory phase of EPIGEPS.

**Strengthening the Capacity of OCCGE Member Countries
in the Management of Public Health Programs**

Objective
Goal

- ♦ To provide OCCGE Member Countries with a permanent capacity to effectively train and utilize mid- and local-level managers of public health programs

Strategy

- ♦ Training will consist of a one-month introductory course in management theory and techniques followed by 23 months of closely supervised on-the-job training emphasizing the application of management skills in problem solving. Trainees will work closely with their counterparts in the Field Epidemiology Training Program.

Curriculum

- ♦ The introductory course will cover the following areas:

Human Resource Management (supervision, performance evaluation, negotiating skills, conflict resolution, motivation, report writing, oral presentations, employee development, etc.)

Financial Management (budgeting, planning, resource allocation)

Program Management (information systems, logistics, evaluation, computer applications)

Expected Outputs

- ♦ Improved linkages between program managers and epidemiologists
- ♦ Improved efficiency of existing public health programs through enhanced utilization of existing human and financial resources
- ♦ Improved planning and prioritization of new program initiatives
- ♦ Improved communications between program managers and their counterparts in international donor agencies (project development as well as monitoring and evaluation of existing programs)
- ♦ Improved interdepartmental communications within the MOH

**Strengthening the Capacity of OCCGE Member Countries
in the Application of Epidemiology in Public Health Programs**

Goal Objective

- ♦ To provide the Ministries of Health in OCCGE Member Countries with a permanent capacity to recruit, train, and utilize epidemiologists in the practice of public health

Strategy

- ♦ Training will consist of a one-month introductory course in applied epidemiology and biostatistics followed by 23 months of on-the-job training emphasizing the use of epidemiology in disease prevention and control programs. Trainees will work closely with their counterparts in the Essential Management Training Program.

Curriculum

- ♦ The introductory course will cover the following areas:

Descriptive Epidemiology (time, place and person; surveillance techniques)

Analytic Epidemiology (case-control studies, cohort studies)

Biostatistics (test for significance, rates/ratios/proportions, regression, multivariate analysis, etc.)

Disease Topics (infectious and non-infectious diseases of public health importance in W. Africa)

Expected Outputs

- ♦ Improved linkages between program epidemiologists and program managers
- ♦ Improved utilization of existing data bases and health information systems
- ♦ Improved utilization of data for decision making by policy makers
- ♦ Improved ability to monitor and track the impact of program interventions

C.D.C.

**Epidemiology/Management Training Program
Project Development Costs
Budget Estimate
12/91 - 8/92**

Technical Assistance	\$132,000
Medical epidemiologists, program managers, management consultants	
Course Material Development/Production	\$ 40,000
Travel/Per Diem	\$ 75,000
Foreign & Domestic	
Program Support	<u>\$ 32,000</u>
Atlanta	
Total	\$279,000

(EPO/IHPO combined effort)